

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08647

CERTIFICATE OF DEATH

8666

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park Spencer	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Station Hospital, USNAS, Patuxent River, Maryland		d. STREET ADDRESS 169 Prospect Street RFD #1, Box 387	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Olive First Jane Middle ALLEN Last		4. DATE OF DEATH Month August Day 9 Year 19 56	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Aug. 1956
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William G. ALLEN		14. MOTHER'S MAIDEN NAME Alma Jane SAUNDERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Station Hospital, USNAS		U.S. Navy Records Patuxent River, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature Birth, Neonatal death DUE TO (b) 7766 Conditions, if any, which gave rise to immediate case (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 13 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 Aug , 19 56 , to 9 Aug , 19 56 , that I last saw the deceased olive on 9 August , 19 56 , and that death occurred at 10:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Station Hospital, USNAS, 8-9-56			
ACTUAL SIGNATURE C. F. WOOLEY		M.D. Station Hospital, USNAS, 8-9-56	
PHYSICIAN'S NAME (Type) C. F. WOOLEY, LT MC USNR		Patuxent River, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 11/56	
22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or county) (State) Great Mills, St. Mary's, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Chaplin Hopkins, N.A.S., Patuxent River		24a. REC'D BY REGISTRAR 8/14/56	
24b. REGISTRAR'S SIGNATURE Patuxent River			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2212

NAME OF DECEASED JAMES EARL RAY		AGE 35		SEX Male		RACE White		DATE OF BIRTH 12-1-29		PLACE OF BIRTH MOBILE, ALA.	
MANNER OF DEATH Suicide		CAUSE OF DEATH Gunshot wound		SITE OF DEATH Room 306, Lorraine Hotel		CITY OF DEATH New Orleans, La.		STATE OF DEATH Louisiana		COUNTY OF DEATH Orleans	
OCCUPATION None		EDUCATION High School		RELIGION Catholic		MARRIAGE Never married		SINGLE OR MARRIED Single		DATE OF MARRIAGE	
DATE OF DEATH 4-4-68		TIME OF DEATH 10:00 AM		PLACE OF DEATH Room 306, Lorraine Hotel		CITY OF DEATH New Orleans, La.		STATE OF DEATH Louisiana		COUNTY OF DEATH Orleans	
DATE OF REPORT 4-10-68		TIME OF REPORT 10:00 AM		PLACE OF REPORT New Orleans, La.		CITY OF REPORT New Orleans, La.		STATE OF REPORT Louisiana		COUNTY OF REPORT Orleans	
REPORTED BY JAMES EARL RAY		RELATIONSHIP Deceased		SIGNATURE James Earl Ray		ADDRESS Room 306, Lorraine Hotel		CITY New Orleans, La.		STATE Louisiana	
DATE OF INTERVIEW 4-10-68		TIME OF INTERVIEW 10:00 AM		PLACE OF INTERVIEW New Orleans, La.		CITY OF INTERVIEW New Orleans, La.		STATE OF INTERVIEW Louisiana		COUNTY OF INTERVIEW Orleans	
INTERVIEWED BY JAMES EARL RAY		RELATIONSHIP Deceased		SIGNATURE James Earl Ray		ADDRESS Room 306, Lorraine Hotel		CITY New Orleans, La.		STATE Louisiana	

BUREAU V. 1

APR 13 1968

RECEIVED

1 8667 88648 Reg. Dist. No. 282 1 8667 CERTIFICATE OF DEATH 1. PLACE OF DEATH o. COUNTY St Mary's MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown c. LENGTH OF STAY IN 1b D.O.A. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Piney Point d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Mary's Hospital d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ 3. NAME OF DECEASED (Type or print) First Middle Last Joseph Alan Ball 4. DATE OF DEATH Month Day Year Aug. 9, 1956 5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH June 29, 1956 9. AGE (In years lost birthday) yrs. 1 11 Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME George C. Ball 14. MOTHER'S MAIDEN NAME Ann C. Redman 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address Ann C. Redman Piney Point, Maryland 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Broncho- 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mongolism (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from June 29, 1956, to Aug 9, 1956, that I last saw the deceased alive on Aug 8, 1956, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Wm. H. Patrick M.D. Lexington Park Md. Aug 10, 1956 PHYSICIAN'S NAME (Type) William H. Patrick M.D. 323 Midway Drive Lexington Park, Md. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 8/10/56 22c. NAME OF CEMETERY OR CREMATORY St George's 22d. LOCATION (City, town, or county) (State) Valley Lee, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Clarke Mattingley Leonardtown, Md. 24a. REC'D BY REGISTRAR DATE 8/13/56 24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOSEPH ALAN HALL		SEX MALE	
DATE OF BIRTH JAN 29 1929		PLACE OF BIRTH BALTIMORE, MARYLAND	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
PLACE OF DEATH BALTIMORE, MARYLAND		DATE OF DEATH AUG 10 1956	
NAME OF PHYSICIAN DR. J. J. HEDGECOCK		NAME OF HOSPITAL BALTIMORE HOSPITAL	
NAME OF FUNERAL HOME J. J. HEDGECOCK		NAME OF BURIAL PLACE BALTIMORE CEMETERY	
NAME OF NEXT OF KIN J. J. HEDGECOCK		NAME OF WITNESS J. J. HEDGECOCK	
NAME OF REGISTRAR J. J. HEDGECOCK		NAME OF CLERK J. J. HEDGECOCK	

BUREAU V. 1

AUG 10 1956

RECEIVED

8668 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

88649

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE TEXAS b. COUNTY EL PASO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EL PASO 80x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 78 ST. MARYS HOSPITAL		d. STREET ADDRESS 1407 Golden Hill Terr.	
3. NAME OF DECEASED (Type or print) First EMILY Middle MAUDE Last BERNARD		4. DATE OF DEATH Month AUGUST Day 8 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 11, 1897
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		10b. KIND OF BUSINESS OR INDUSTRY HOTEL	11. BIRTHPLACE (State or foreign country) ENGLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM LESSAMAN	
14. MOTHER'S MAIDEN NAME MARTHA CROMPTON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NO		17. INFORMANT JACK E. PALMER - US NAS PATUXENT RIVER, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension - Renal Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 30, 1956 to Aug 8, 1956 , that I last saw the deceased alive on Aug 8, 1956 , and that death occurred at 2145th from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. H. Patrick		DATE SIGNED Aug 8, 1956	
PHYSICIAN'S NAME (Type) Wm. H. PATRICK, M.D.		ADDRESS (Street, city or town, state) LEXINGTON PARK, MARYLAND.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/9/56	22c. NAME OF CEMETERY OR CREMATORY FORT BLISS NATIONAL CEM.	22d. LOCATION (City, town, or county) (State) EL PASO, TEXAS
23. FUNERAL DIRECTOR'S SIGNATURE G. B. Robinson		ADDRESS LEONARDTOWN, Md.	
24a. REC'D BY REGISTRAR 8/9/56		24b. REGISTRAR'S SIGNATURE Adams Hausly	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8669

CERTIFICATE OF DEATH

Reg. Dist. No.

18650
282

1. PLACE OF DEATH a. COUNTY ST MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE CALIFORNIA b. COUNTY LOS ANGELES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VAN NUYS	
c. LENGTH OF STAY IN 1b 7 days		d. STREET ADDRESS 14904 HAMLIN STREET	
d. NAME OF HOSPITAL (If not in institution, give street and city) STATION HOSPITAL U. S. NAVAL AIR STATION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PATUXENT RIVER, MARYLAND JAMES PATRICK CRONIN		4. DATE OF DEATH Month AUGUST Day 19 Year 1956	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/1898
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 19 Days 19 Hours 56	IF UNDER 24 HRS. Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY Lumber	11. BIRTHPLACE (State or foreign country) South Dakota
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN S. CRONIN	
14. MOTHER'S MAIDEN NAME ANNA M. WHELAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. WW 1		17. INFORMANT JAMES F. RUMSEY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 19hrs 55 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/18/56 , 19 56 , to 8/19/ , 19 56 , that I last saw the deceased alive on 8/19/ , 19 56 , and that death occurred at 530 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Station Hospital, U.S. Naval Air Station Patuxent River, Maryland DATE SIGNED 8/19/56			
ACTUAL SIGNATURE J. E. Szakacs M.D.		PHYSICIAN'S NAME (Type) J. E. SZAKACS LT MC USNR	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation	22b. DATE THEREOF 8/21/56	22c. NAME OF CEMETERY OR CREMATORY Leonardtwn, Md.	22d. LOCATION (City, town, or county) (State) Los Angeles, California
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson		24a. REC'D BY REGISTRAR DATE 8/20/56	24b. REGISTRAR'S SIGNATURE Alan P. Houser

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. PLACE OF BIRTH	
6. DATE OF DEATH		7. TIME OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESS		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF CORONER		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF TOWNSHIP CLERK		19. SIGNATURE OF COUNTY CLERK		20. SIGNATURE OF STATE CLERK	
21. SIGNATURE OF VICE-MAYOR		22. SIGNATURE OF ALDERMAN		23. SIGNATURE OF COUNCILMAN		24. SIGNATURE OF COMMISSIONER		25. SIGNATURE OF SUPERVISOR	
26. SIGNATURE OF JUSTICE OF THE PEACE		27. SIGNATURE OF SHERIFF		28. SIGNATURE OF TOWNSHIP CLERK		29. SIGNATURE OF COUNTY CLERK		30. SIGNATURE OF STATE CLERK	
31. SIGNATURE OF VICE-MAYOR		32. SIGNATURE OF ALDERMAN		33. SIGNATURE OF COUNCILMAN		34. SIGNATURE OF COMMISSIONER		35. SIGNATURE OF SUPERVISOR	
36. SIGNATURE OF JUSTICE OF THE PEACE		37. SIGNATURE OF SHERIFF		38. SIGNATURE OF TOWNSHIP CLERK		39. SIGNATURE OF COUNTY CLERK		40. SIGNATURE OF STATE CLERK	
41. SIGNATURE OF VICE-MAYOR		42. SIGNATURE OF ALDERMAN		43. SIGNATURE OF COUNCILMAN		44. SIGNATURE OF COMMISSIONER		45. SIGNATURE OF SUPERVISOR	
46. SIGNATURE OF JUSTICE OF THE PEACE		47. SIGNATURE OF SHERIFF		48. SIGNATURE OF TOWNSHIP CLERK		49. SIGNATURE OF COUNTY CLERK		50. SIGNATURE OF STATE CLERK	
51. SIGNATURE OF VICE-MAYOR		52. SIGNATURE OF ALDERMAN		53. SIGNATURE OF COUNCILMAN		54. SIGNATURE OF COMMISSIONER		55. SIGNATURE OF SUPERVISOR	
56. SIGNATURE OF JUSTICE OF THE PEACE		57. SIGNATURE OF SHERIFF		58. SIGNATURE OF TOWNSHIP CLERK		59. SIGNATURE OF COUNTY CLERK		60. SIGNATURE OF STATE CLERK	
61. SIGNATURE OF VICE-MAYOR		62. SIGNATURE OF ALDERMAN		63. SIGNATURE OF COUNCILMAN		64. SIGNATURE OF COMMISSIONER		65. SIGNATURE OF SUPERVISOR	
66. SIGNATURE OF JUSTICE OF THE PEACE		67. SIGNATURE OF SHERIFF		68. SIGNATURE OF TOWNSHIP CLERK		69. SIGNATURE OF COUNTY CLERK		70. SIGNATURE OF STATE CLERK	
71. SIGNATURE OF VICE-MAYOR		72. SIGNATURE OF ALDERMAN		73. SIGNATURE OF COUNCILMAN		74. SIGNATURE OF COMMISSIONER		75. SIGNATURE OF SUPERVISOR	
76. SIGNATURE OF JUSTICE OF THE PEACE		77. SIGNATURE OF SHERIFF		78. SIGNATURE OF TOWNSHIP CLERK		79. SIGNATURE OF COUNTY CLERK		80. SIGNATURE OF STATE CLERK	
81. SIGNATURE OF VICE-MAYOR		82. SIGNATURE OF ALDERMAN		83. SIGNATURE OF COUNCILMAN		84. SIGNATURE OF COMMISSIONER		85. SIGNATURE OF SUPERVISOR	
86. SIGNATURE OF JUSTICE OF THE PEACE		87. SIGNATURE OF SHERIFF		88. SIGNATURE OF TOWNSHIP CLERK		89. SIGNATURE OF COUNTY CLERK		90. SIGNATURE OF STATE CLERK	
91. SIGNATURE OF VICE-MAYOR		92. SIGNATURE OF ALDERMAN		93. SIGNATURE OF COUNCILMAN		94. SIGNATURE OF COMMISSIONER		95. SIGNATURE OF SUPERVISOR	
96. SIGNATURE OF JUSTICE OF THE PEACE		97. SIGNATURE OF SHERIFF		98. SIGNATURE OF TOWNSHIP CLERK		99. SIGNATURE OF COUNTY CLERK		100. SIGNATURE OF STATE CLERK	

BUREAU V. S.

AUG 21 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8670
CERTIFICATE OF DEATH

08651
282
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bushwood c. LENGTH OF STAY IN 1b 20 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bushwood d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alexander Abraham Downs		4. DATE OF DEATH Month Day Year Aug. 3 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1872
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Downs		14. MOTHER'S MAIDEN NAME Dorsha Redman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 min 5 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15 1953 , to Aug 3 1956 , that I last saw the deceased alive on Aug 3 1956 , and that death occurred at 9:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Wm D Boyd M.D. Leonardtown Md 8/4/56			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) WILLIAM D. BOYD M.D. LEONARDTOWN MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6, 56	
22c. NAME OF CEMETERY OR CREMATORY Our Lady's		22d. LOCATION (City, town, or county) (State) Medley's Neck Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR 8/6/56	
ADDRESS Leonardtown, Md.		24b. REGISTRAR'S SIGNATURE Glen D. Houser	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF BIRTH [Faint text]</p>		<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. DATE OF DEATH [Faint text]</p>		<p>8. PLACE OF DEATH [Faint text]</p>		<p>9. CAUSE OF DEATH [Faint text]</p>	
<p>10. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>11. SIGNATURE OF DECEASED [Faint text]</p>		<p>12. SIGNATURE OF WITNESS [Faint text]</p>	
<p>13. SIGNATURE OF DECEASED [Faint text]</p>		<p>14. SIGNATURE OF WITNESS [Faint text]</p>		<p>15. SIGNATURE OF DECEASED [Faint text]</p>	
<p>16. SIGNATURE OF WITNESS [Faint text]</p>		<p>17. SIGNATURE OF DECEASED [Faint text]</p>		<p>18. SIGNATURE OF WITNESS [Faint text]</p>	
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<p>82. SIGNATURE OF WITNESS [Faint text]</p>		<p>83. SIGNATURE OF DECEASED [Faint text]</p>		<p>84. SIGNATURE OF WITNESS [Faint text]</p>	
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<p>91. SIGNATURE OF DECEASED [Faint text]</p>		<p>92. SIGNATURE OF WITNESS [Faint text]</p>		<p>93. SIGNATURE OF DECEASED [Faint text]</p>	
<p>94. SIGNATURE OF WITNESS [Faint text]</p>		<p>95. SIGNATURE OF DECEASED [Faint text]</p>		<p>96. SIGNATURE OF WITNESS [Faint text]</p>	
<p>97. SIGNATURE OF DECEASED [Faint text]</p>		<p>98. SIGNATURE OF WITNESS [Faint text]</p>		<p>99. SIGNATURE OF DECEASED [Faint text]</p>	
<p>100. SIGNATURE OF WITNESS [Faint text]</p>		<p>101. SIGNATURE OF DECEASED [Faint text]</p>		<p>102. SIGNATURE OF WITNESS [Faint text]</p>	

BUREAU V. 1

AUG 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8671
CERTIFICATE OF DEATH

Reg. Dist. No. 08652282

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b SCOTLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARYS HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NANNIE Middle CANE Last GOUGH				4. DATE OF DEATH Month AUGUST Day 24 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 MAY 1883	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES SMITH		14. MOTHER'S MAIDEN NAME ELIZA FRAZIER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT MARY B. HEWLETT - SCOTLAND, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CV Accident - 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days 10 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) SCOTLAND				20g. (County) MARYLAND			
21. I certify that I attended the deceased from Aug 24, 1956 , to Aug 24, 1956 , that I last saw the deceased alive on Aug 24, 1956 , and that death occurred at 8:55 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm D Boyd				ADDRESS (Street, city or town, state) Leonardtown			
PHYSICIAN'S NAME (Type) Wm. D. Boyd, M.D.				DATE SIGNED 8/28/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/27/56		22c. NAME OF CEMETERY OR CREMATORY ST. LUKES CEMETERY		22d. LOCATION (City, town, or county) (State) SCOTLAND, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson				ADDRESS LEONARDTOWN, Md.			
24a. REC'D BY REGISTRAR 8/28/56		24b. REGISTRAR'S SIGNATURE Alan D. Housery					

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1.55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8672 **CERTIFICATE OF DEATH**

08653

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ST. MARYS		MARYLAND		STATE MARYLAND		COUNTY ST. MARYS	
CITY (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS RURAL				STREET ADDRESS (If rural give location) RURAL			
3. NAME OF DECEASED (First) (Middle) (Last) MARY BEATRICE HOLLY				4. DATE OF DEATH (Month) (Day) (Year) AUG. 30, 1956			
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH DEC. 25, 1908	9. AGE last birthday 47 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN FREDERICK				14. MOTHER'S MAIDEN NAME CATHERINE L. THOMAS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS LOUIS C. HOLLY - LEONARDTOWN, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 171X IMMEDIATE CAUSE (A) Carcinoma of cervix with infiltration and metastases to pelvic ANTECEDENT CAUSE(S) DUE TO (B) and metastases to pelvic DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 1954		19b. MAJOR FINDINGS OF OPERATION CA Cervix		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1955 , to Aug 30, 1956 , that I last saw the deceased alive on Aug 24, 1956 , and that death occurred at 11:10 PM , from the causes and on the date stated above. SIGNATURE Roy Guyther M.D. Mechanicville ADDRESS (Street, city, town, state) 8131/56 DATE SIGNED 8/31/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 9/3/56		NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY		LOCATION (City, town, or county) (State) BUSHWOOD, Md.	
24. REC'D BY REGISTRAR 9/4/56		REGISTRAR'S SIGNATURE Glenn D. Hanner		25. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson		ADDRESS LEONARDTOWN, Md.	

28

BUREAU V. S.

SEP 5 1956

RECEIVED
SEP 5 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8673
CERTIFICATE OF DEATH

Reg. Dist. No.

08654

282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Hervey Middle S. Last Knight Jr.		4. DATE OF DEATH Month August Day 24 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1905
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 10 Days 5 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHOTOGRAPH		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hervey S. Knight		14. MOTHER'S MAIDEN NAME Annie Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 322-05-3396	
17. INFORMANT Anita D. Knight		Address Compton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 199.3 DUE TO Peritonitis, diffuse, peracute Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (a), stating the <u>underlying</u> cause last. (b) Calacemo) Colon and small intestine DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) (b) (c) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 20, 1956 to Aug 24, 1956 that I last saw the deceased alive on Aug 23, 1956 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) At DATE SIGNED 			
ACTUAL SIGNATURE Micahel Barbarich M.D.			
PHYSICIAN'S NAME (Type) Micahel Barbarich M.D. Leonardtwn, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/27/56	22c. NAME OF CEMETERY OR CREMATORY Oak Hill	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly		24a. REC'D BY REGISTRAR DATE 8/24/56	
ADDRESS 131 11th. St. S.E. Washington, D.C.		24b. REGISTRAR'S SIGNATURE Glean D. House	

1956 25 511

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8674

CERTIFICATE OF DEATH

Reg. Dist. No.

08655

282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 6 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Kincaid Lee		4. DATE OF DEATH Month Day Year Aug. 15 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6 1866
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 5 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & sawyer		10b. KIND OF BUSINESS OR INDUSTRY Farm & Sawmill	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Lee		14. MOTHER'S MAIDEN NAME Margaret Kincaid	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Edward N. Lee Mechanicsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic C V disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 9 1956 to Aug 15 1956 , that I last saw the deceased alive on Aug 13 1956 , and that death occurred at 5 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville DATE SIGNED ACTUAL SIGNATURE J. Roy Guyther M.D. Mechanicsville PHYSICIAN'S NAME (Type) J. Roy Guyther M.D. Mechanicsville Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/18/1956	
22c. NAME OF CEMETERY OR CREMATORY Jerusalem Christian		22d. LOCATION (City, town, or county) (State) Bel Air Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley, Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 8/17/56	
24b. REGISTRAR'S SIGNATURE Glenn S. Hauer			

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. A.

JUN 20 1956

RECEIVED

Form with fields for administrative use, including date and signature lines.

Page 4
 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 8675
 CERTIFICATE OF DEATH

08656

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River 2 yr 8 mos				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Station Hospital, USNAS, Patuxent River, Maryland				d. STREET ADDRESS 903C MOQ, USNAS			
3. NAME OF DECEASED (Type or print) John Oglesby LONG Jr.				4. DATE OF DEATH August 13 19 56			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-22		9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aviator		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Gates, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rev. John Oglesby LONG Sr.				14. MOTHER'S MAIDEN NAME Hortense Duncan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1943 till present		17. INFORMANT U.S. Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 860X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Immediate							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aircraft crashed into water from low altitude			
20c. TIME OF INJURY Month, Day, Year 1000 a.m. Aug 13 1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Aircraft		20f. (City or town) U.S. Naval Air Station (State) Patuxent River, Maryland	
21. I certify that I attended the deceased from Aug 13 1956 , to Aug 13 1956 , that I last saw the deceased alive on Aug 13 1956 , and that death occurred at 1001AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE C.F. Wooley				ADDRESS (Street, city or town, state) Station Hospital, U.S. Naval Air Station			
PHYSICIAN'S NAME (Type) C.F. WOOLEY LT MC USNR				DATE SIGNED 8-13-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson				ADDRESS Leonardtown, Md.		24a. REC'D BY REGISTRAR 8/20/56	
						24b. REGISTRAR'S SIGNATURE Glenn D. Houser	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES M. KELLEY		45		M		W		1910		BALTIMORE		MD		USA			
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
AUG 20 1956		BALTIMORE		HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		CATHOLIC		MARRIED			
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL		SIGNATURE OF CREMATION		SIGNATURE OF INTERMENT		SIGNATURE OF OTHER	
J. M. KELLEY		J. M. KELLEY		J. M. KELLEY		J. M. KELLEY		J. M. KELLEY		J. M. KELLEY		J. M. KELLEY		J. M. KELLEY		J. M. KELLEY	

BUREAU V. S.

AUG 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08657

8676

CERTIFICATE OF DEATH

Reg. Dist. No.

281

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 13 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First William Middle Vincent Last McGee		4. DATE OF DEATH Month August Day 20 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 22 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR Months 10 Days 20 IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charlie McGee		14. MOTHER'S MAIDEN NAME Emily Guy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No NONE		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Nettie Joy		Address Hollywood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1 , 19 56 , to Aug 20 , 19 56 , that I last saw the deceased alive on Aug 20 , 19 56 , and that death occurred at 4:30 P M , from the causes and on the date stated above.			
ACTUAL SIGNATURE PJ Ben		ADDRESS (Street, city or town, state) Grant Mills Md	
PHYSICIAN'S NAME (Type) 		DATE SIGNED 8/24/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY St John's		22d. LOCATION (City, town, or county) (State) Hollywood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Md.	
24a. REC'D BY REGISTRAR DATE 8/21/56		24b. REGISTRAR'S SIGNATURE Local Registrar	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. S.

AUG 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8677
CERTIFICATE OF DEATH

08658
282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>St Marys</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>near Hughesville (Rural)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St Mary's Hosp</i>		d. STREET ADDRESS <i>08X-2</i>	
3. NAME OF DECEASED (Type or print) <i>Fanny Pearl</i>		4. DATE OF DEATH Month <i>AUG</i> Day <i>14</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 1907</i>
9. AGE (In years last birthday) <i>48</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph A. Moran</i>		14. MOTHER'S MAIDEN NAME <i>Goldie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Joseph A. Moran</i>		Address <i>Hughesville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized metastases from</i> <i>174X</i> DUE TO <i>carcinoma - uterus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>18 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>Aug 10</i> , 19 <i>56</i> , to <i>Aug 14</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Aug 13</i> , 19 <i>56</i> , and that death occurred at <i>4 A</i> . M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Roy Hughes</i> M.D.		DATE SIGNED <i>Mechanicsville, Md 8/14/56</i>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-16-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's</i>		22d. LOCATION (City, town, or county) <i>Bryantown, Md.</i> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home</i>		ADDRESS <i>Waldorf, Md.</i>	
24a. REC'D BY REGISTRAR <i>Aug 20 1956</i>		24b. REGISTRAR'S SIGNATURE <i>William D. Sawyer</i>	

BUREAU V. S.

1956 08 5.10

RECEIVED

8678

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Bushwood				c. LENGTH OF STAY IN 1b 46 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Catherine L. Reeves				4. DATE OF DEATH Month August Day 13 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 21, 1872	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 9 Days 23		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John B. Lyon				14. MOTHER'S MAIDEN NAME Liza Hayden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Thomas B. Reeves Address Bushwood, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Compton, Maryland				(County) (State) 			
21. I certify that I attended the deceased from May 15, 1953 to Aug 13, 1956 , that I last saw the deceased alive on Aug 12, 1956 , and that death occurred at 8:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Compton, Maryland DATE SIGNED 8/14/56							
ACTUAL SIGNATURE Joseph E. Gill M.D.				PHYSICIAN'S NAME (Type) Joseph E. Gill, M.D. Compton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/56		22c. NAME OF CEMETERY OR CREMATORY Christ Church		22d. LOCATION (City, town, or county) (State) Chaptico, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE 8/16/56		24b. REGISTRAR'S SIGNATURE Glen D. Houser	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

NAME OF DECEASED <i>John J. Smith</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Aug 10 1956</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Boston</i>		COUNTY <i>Suffolk</i>	
MANNER OF DEATH <i>Natural</i>		CAUSE OF DEATH <i>Heart Disease</i>		DISEASE OR INJURY <i>Myocardial Infarction</i>		PERIOD OF ILLNESS <i>2 weeks</i>	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 1

AUG 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8679

CERTIFICATE OF DEATH

Reg. Dist. No.

88660

282

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARYS HOSPITAL		d. STREET ADDRESS RURAL	
3. NAME OF DECEASED (Type or print) JOHN EDWARD REID		4. DATE OF DEATH Month AUGUST Day 27 Year 1956	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 7, 1912
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFER		10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MORGAN REID		14. MOTHER'S MAIDEN NAME MILINDA GOLDRING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -----	
17. INFORMANT VERONICA RETD * RIDGE, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 053.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) abscess Teeth. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 5:00 a.m. Aug 27 1956		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 26, 1956 , to August 27, 1956 , that I last saw the deceased alive on August 27, 1956 , and that death occurred at 5:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles Greenwell M.D.		ADDRESS (Street, city or town, state) Leonardtown Md.	
PHYSICIAN'S NAME (Type) CHARLES GREENWELL, M.D.		LEONARDTOWN, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/30/56	22c. NAME OF CEMETERY OR CREMATORY ST. PETERS CEMETERY	22d. LOCATION (City, town, or county) (State) RIDGE, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson		24a. REC'D BY REGISTRAR DATE 8/28/56	
ADDRESS LEONARDTOWN, Md.		24b. REGISTRAR'S SIGNATURE Glean D. Housery	

CERTIFICATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH

REGISTRATION

DEATH

DATE

TIME

PLACE

CAUSE

SEX

AGE

RACE

EDUCATION

OCCUPATION

RELIGION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. A.

AUG 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8680
CERTIFICATE OF DEATH

Reg. Dist. No.

18661
287

1. PLACE OF DEATH o. COUNTY St Mary's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Compton c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 343 South Newkirk e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Norman George Schaller				4. DATE OF DEATH Month Day Year Aug. 6, 1956					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18, 1894		9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker				10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E. Schaller						14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Elizabeth Schaller 343 S. Newkirk Street					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary insufficiency DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 15 min. 1 year.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 Aug., 1956 , to 6 Aug., 1956 , that I last saw the deceased alive on 6 Aug., 1956 , and that death occurred at 5:00 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Joseph E. Gill, M.D. Compton, Md. 8/6/56 PHYSICIAN'S NAME (Type) Joseph E. Gill M.D. Compton, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8/10/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wendell J. Dippell 312 S. Highland Avenue Baltimore, Md.						24a. REC'D BY REGISTRAR DATE 1956		24b. REGISTRAR'S SIGNATURE Alexander	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1920		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
Carpenter		High School		Married		Catholic		White		White		5' 10"		175	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
Myocardial Infarction		Natural		Home		JAN 10 1955		10:15 AM		10:15		10:15		10:15	
PHYSICIAN		HOSPITAL		NURSE		CORONER		JURY		JURY		JURY		JURY	
Dr. J. H. Smith		St. Mary's Hospital		Mrs. J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH		TENTH OF DEATH		HUNDREDTH OF DEATH		THOUSANDTH OF DEATH	
JAN 10 1955		10:15 AM		10:15		10:15		10:15		10:15		10:15		10:15	
PLACE OF DEATH		CITY		STATE		COUNTRY		RACE		COLOR		HEIGHT		WEIGHT	
Home		Mobile		Alabama		United States		White		White		5' 10"		175	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
Myocardial Infarction		Natural		Home		JAN 10 1955		10:15 AM		10:15		10:15		10:15	
PHYSICIAN		HOSPITAL		NURSE		CORONER		JURY		JURY		JURY		JURY	
Dr. J. H. Smith		St. Mary's Hospital		Mrs. J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY		SIGNATURE OF JURY	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH		TENTH OF DEATH		HUNDREDTH OF DEATH		THOUSANDTH OF DEATH	
JAN 10 1955		10:15 AM		10:15		10:15		10:15		10:15		10:15		10:15	
PLACE OF DEATH		CITY		STATE		COUNTRY		RACE		COLOR		HEIGHT		WEIGHT	
Home		Mobile		Alabama		United States		White		White		5' 10"		175	

BUREAU V. S.

AUG 8 1956

RECEIVED

Item 7 Film G202 9-4-56 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8681
CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH o. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARY'S HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE SYLVESTER TENNYSON				4. DATE OF DEATH Month Day Year AUGUST 22 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1881	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 6 25		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT George S. Tennyson Address Avenue, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Edema of lungs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) stroke			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 11 , 19 56 , to Aug 22 , 19 56 , that I last saw the deceased alive on August 22 , 19 56 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles Greenwell				ADDRESS (Street, city or town, state) Leonardtown Md.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) CHARLES GREENWELL M.D.				LOCATION (City, town, or county) (State) LEONARDTOWN MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/25/56		22c. NAME OF CEMETERY OR CREMATORY St Joseph's		22d. LOCATION (City, town, or county) (State) Morganza, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Address Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE 8/24/56		24b. REGISTRAR'S SIGNATURE Claw D. Hauer	

CERTIFICATE OF DEATH

DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	
PLACE		CITY	
STATE		COUNTY	
FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE	
WASHINGTON, D.C.		BALTIMORE, MD	
RECEIVED		BUREAU V. S.	
JUN 27 1956		JUN 27 1956	

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 8682
 CERTIFICATE OF DEATH

08663

Reg. Dist. No. 252

1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn				c. LENGTH OF STAY IN 1b 37 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				d. STREET ADDRESS Clements			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Joseph Middle Leo Last Vallandingham				4. DATE OF DEATH Month Aug. Day 7, Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1884		9. AGE (In years lost in day) yrs. 72	IF UNDER 1 YEAR Months 4 Days 19 Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Leo Vallandingham				14. MOTHER'S MAIDEN NAME Fannie Bailey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-24-1194		17. INFORMANT Address Mrs Addie Vallandingham Clements, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cc of Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 6 month
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1956 , to Aug 7 , 19 56 , that I last saw the deceased alive on Aug 6 , 19 56 , and that death occurred at 2:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Leonardtwn, Maryland DATE SIGNED 8/8/56							
ACTUAL SIGNATURE W.D. Boyd M.D.		PHYSICIAN'S NAME (Type) William D. Boyd M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/56		22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Md.		24a. REC'D BY REGISTRAR DATE 8/10/56	
				24b. REGISTRAR'S SIGNATURE Glenn D. Hauser			

BUREAU V. M.

1956 82 500

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08664
8683 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VALLEY LEE		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VALLEY LEE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN R. WATTS				4. DATE OF DEATH Month AUGUST Day 26 Year 1956			
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 27, 1909		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY LABOR		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER WATTS				14. MOTHER'S MAIDEN NAME MARY BENNETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW2 578-18-0301		17. INFORMANT Address Mrs. Lillian Brown, Valley Lee, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychopathic						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in stream of water 1/4 mile from Valley Lee Md					
20c. TIME OF INJURY Hour 2 o. m. Aug 26 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Stream under highway		20f. (City or town) (County) (State) Valley Lee St Mary Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE P. J. BEAN		M.D. P. J. BEAN		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Aug 27/56	
EXAMINER'S NAME (Type) P. J. BEAN		M.D. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/29/1956		22c. NAME OF CEMETERY OR CREMATORY ST. GEORGE'S		22d. LOCATION (City, town, or county) (State) VALLEY LEE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY, LEONARDTOWN, MD.				24a. REC'D BY REGISTRAR 8/27/56		24b. REGISTRAR'S SIGNATURE W. J. Brown	

RECEIVED

SEP 4 1956

BUREAU V. 3

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8681 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

88665

Item 8, Film G201, 8/23/56 bh CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Daniel Middle Lee Last Woods		4. DATE OF DEATH Month August Day 12 Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1956
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elbert Woods		14. MOTHER'S MAIDEN NAME Mary D. Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Elbert Woods		Address Hermanville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Enterocolitis DUE TO (b) and malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 week 3 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 7, 1956 , to Aug 12, 1956 , that I last saw the deceased alive on Aug 11, 1956 , and that death occurred at 7 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8/12/56			
ACTUAL SIGNATURE P.J. Bean M.D.		M.D.	
PHYSICIAN'S NAME (Type) P.J. Bean M.D.		Great Mills, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/13/56	
22c. NAME OF CEMETERY OR CREMATORY St Aloysius		22d. LOCATION (City, town, or county) (State) Leonardtown, Maryland	
23. BURIAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Md.	
24a. REC'D BY REGISTRAR DATE 8/12/56		24b. REGISTRAR'S SIGNATURE W. Clarke Mattingley	

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BUREAU V. S.

AUG 14 1956

RECEIVED

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18 8685 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 8666 282

1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avenue				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avenue			
c. LENGTH OF STAY IN 1b Life				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lynda Middle Dianne Last Young				4. DATE OF DEATH Month Aug. Day 4, Year 19 56			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 51		9. AGE (In years last birthday) 5 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Edward Young				14. MOTHER'S MAIDEN NAME Gertrude Elizabeth Armstrong			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT James E. Young Address Avenue, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Periarteritis nodosa 456X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Louette M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Louette				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/7/56		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Busshwood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtwn, Md.				24a. REC'D BY REGISTRAR 8/6/56		24b. REGISTRAR'S SIGNATURE Glenn D. Hauser	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG 8 1956

RECEIVED